CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4501
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

CONFIDENTIAL

APPLICATION FOR VOLUNTARY TREATMENT OPTION PROGRAM
(A Professional Assistance Program)

As a condition for entry into the VTO program, the applicant can not have committed any offense, other than the status of being chemically dependent or impaired which otherwise constitutes a ground for discipline under applicable laws governing my regulated profession.

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LICENSING BOARD: _____ CASE #_____

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APPLICATION FOR THE VOLUNTARY TREATMENT OPTION PROGRAM
(A Professional Assistance Program)

INTRODUCTION

By submitting this application, I request approval to participate in the Voluntary Treatment Option (VTO) for chemically dependent or impaired professionals provided for by 24 *Del. C.* §8735(n). **I hereby certify as a condition to entry into the VTO program that I have not committed any offense, other than the status of being chemically dependent or impaired which otherwise constitutes a ground for discipline under applicable laws governing my regulated profession.**

By submitting this application, I agree that I will:

1. Voluntarily submit to a drug and alcohol screening, evaluation, and assessment at my expense at a specified laboratory or health care facility agreed upon by me and by the Director of the Division of Professional Regulation (DPR) and the chairperson of my State of Delaware professional licensing board or their designees.
2. Voluntarily enter into binding contracts for treatment and monitoring by a different laboratory or health care facility at my own expense. Such contracts must be acceptable to me and to the Director of DPR and the chairperson of my professional licensing board or their designees. Such contract will provide for consent to release to the licensing board designee and the Director of Professional Regulation or his or her designee, information concerning my participation in VTO programs. Such consent is a condition of my admission to the VTO program.
3. Voluntarily comply with any and all restrictions and conditions imposed on my professional practice by the Director of DPR and the chairperson of my professional licensing board as specified in my contract for treatment and monitoring or any amendments thereto as directed by the Director of DPR and/or the chairperson of my licensing board or their designees. I specifically understand and agree that:
   A. My records of participation in the Voluntary Treatment Option will not reflect disciplinary action and will not be considered public records.
   B. My participation in the Voluntary Treatment Option program does not shield or protect me from disciplinary action for professional misconduct either before or after my application for or acceptance in the program
   C. Results from any drug testing performed after acceptance into the VTO program may be used for license disciplinary proceedings.

Date: _____ _____

Applicant Name (printed)

_____

Signature

LICENSING BOARD: _____ CASE #_____

APPLICATION FOR THE VOLUNTARY TREATMENT OPTION PROGRAM
(A Professional Assistance Program)

Incomplete applications will not be considered. All blanks must be completed with responses or N/A.

NAME: _____ LICENSE TYPE: _____
LICENSE NUMBER: _____ YEARS LICENSED: _____
ADDRESS: _____ CITY: _____ _____
STATE: _____ ZIP CODE: _____
PHONE: _____
EMPLOYER: _____ SUPERVISOR: _____
PHONE: _____
LIST ANY OTHER CURRENT EMPLOYER(S):_____
_____

1. I am requesting admission into the VTO Program for the treatment of my chemical dependency. Specifically:
   a) ___ Excessive drug use (specify drug(s) of choice) that leads to impaired functioning.
   _____
   b) ___ Excessive alcohol use/addiction that leads to impaired functioning.
   _____

Please write a brief narrative describing your experience with the chemical(s) noted above.

_____
_____
_____

2. In what other states have you been licensed? _____
3. List all states in which you are practicing.
4. Have you ever participated in a drug or alcohol Diversion Program or a similar program in any state? No_____ Yes_____
   If no, please proceed to question 6.

   Location(s) _____
   Dates of participation (if more than one, give dates for each time) _____
   _____
   _____
   Contact Person(s) _____

5. Have you ever been terminated from or failed to complete any drug or alcohol Diversion Program? No_____ Yes_____

6. Have you ever been placed on probation or had Board action taken against you by any licensing board in the past? No_____ Yes_____

State(s) _____

Date(s) _____

What was the violation? _____

7. Has your professional license ever been suspended, revoked, relinquished, or probated?

No_____ Yes_____

State(s) _____

Date(s) _____

What was the violation? _____

8. Has your driving license ever been suspended, revoked, relinquished, or probated for a drug related or alcohol related incident?

No_____ Yes_____

If yes, please provide a certified copy of your driver's license record.

State(s) _____

Date(s) _____

For what violation? _____

9. Have you ever been convicted of a felony or crime involving controlled substances?

No_____ Yes_____

If yes, please attach copies of the court documents.10. Have you ever been in treatment for a drug and/or alcohol problem?

No_____ Yes_____

How long was your longest period of sobriety and/or abstinence? _____

Where were you in treatment? _____

_____

Date(s) _____

10. Are you in therapy now? No_____ Yes_____

Therapist_____ Phone_____

Address_____

What (if any) medications are you currently taking? _____

_____

11. If you are not in therapy, what are your plans regarding therapy or recovery? _____

_____

12. What is your practice area? (Specify areas of practice and describe direct patient/customer contact.)

_____

_____

13. Do you wish to continue to practice your licensed profession? No_____Yes_____

14. Do you feel safe to practice? No_____ Yes_____

Please explain _____

_____

15. Have you reported your drug or alcohol problem to your supervisor?

No_____ Yes_____

16. Do you have access to your drug of choice at work? No_____ Yes_____

17. What plans, if any, have you made to limit such access? _____

_____

_____

18. What are your goals for participating in this VTO program? _____

_____

_____

19. Does your employer know of your interest in the VTO program?

No_____ Yes_____

If no, what are your plans about informing your employer and when will this occur?

_____

_____

19a. Does the Director of DPR and/or the chairperson of the professional licensing board or their designees have your authorization to discuss your application with your employer?

No_____ Yes_____

20. Does your family or significant other know of your interest in the VTO program?

No_____ Yes_____

If no, what are your plans for informing your family or significant other? _____

_____

21. Who in your life will support your recovery/health maintenance? (identify all)_____

_____

_____

I certify that all information I have provided is complete and accurate.

_____ _____

Applicant's Signature Date

AGREEMENT

In addition to the representations made above, it is understood and agreed that upon acceptance of this application by the Director of the Division of Professional Regulation and approval by the Chairperson of the licensing Board or his or her designee this shall become the agreement specified in 29 *Del. C.* §8735(n)(6). It is understood and agreed that the applicant will not be identified to the participating regulatory Board so long as the applicant is in compliance with the agreement and that the applicant's failure to satisfactorily progress in a treatment program shall be reported to the participating Board's chairperson or his or her designate or to the Director of the Division of Professional Regulation or his or her designate by the treating professional(s). It is further understood and agreed that the applicant will be personally responsible for all costs, fees and charges associated with the Voluntary Treatment Option and treatment program(s).

Application: (Approved) (Disapproved)

State reason(s) for disapproval_____

_____

Assessment facility _____

Treatment facility_____

TREATMENT AND MONITORING CONTRACTS, ONCE EXECUTED, WILL BE ATTACHED TO AND BECOME PART OF THIS AGREEMENT.

PRACTICE RESTRICTIONS WILL BE SPECIFIED BELOW AND MAY BE AMENDED BY FURTHER WRITTEN AGREEMENT, WHICH SHALL ALSO BE ATTACHED TO THIS AGREEMENT.

PRACTICE RESTRICTIONS:

RESTRICTIONS AND AGREEMENT

Date approved by Director DPR_____ **_____**

(SIGNATURE)

Date approved by Board Chairperson or designee _____ **_____**

(SIGNATURE)

AGREEMENT AND PRACTICE RESTRICTIONS ACCEPTED:

_____ **_____**

Applicant's Signature **Date**

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize my treating or evaluating chemical
(Print Name)
dependency specialist _____ to disclose any and all current and
(Print Name)
ongoing written and verbal information to the Director of the Division of Professional Regulation

and/or designee and the chairman and/or his or her designee of the Board of _____.

Check all information to be disclosed:

___	Intake summary	___	Progress reports
___	Treatment plan	___	Discharge summaries
___	History and physical exams	___	Diagnosis, prognosis
___	Monitored Antabuse/Naltrexone report	___	Performance reports
___	Urinalysis or other chemistry reports	___	After Care reports
___	Other_____		

The purpose of this disclosure is to coordinate the rehabilitation process with the Regulatory Licensing Board pursuant to the Voluntary Treatment Option (VTO) under 29 *Del. C.* §8735(n).

This information will be disclosed from records whose confidentiality may be protected by federal law. Federal regulations (42 CFR Part 2) prohibit any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. This general authorization for the release of medical or other information is not sufficient for this purpose.

If a licensee is accepted into the VTO Program and has a signed Diversion Program Contract, this consent will terminate upon completion and/or termination of the VTO Program Contract. This authorization is subject to revocation at any time except to the extent that the program that is to make the disclosure has already taken action in reliance on it. Revocation of this consent will be reported to the Director of the Division of Professional Regulation for determination of noncompliance with the VTO Program, which may be reported to the State Licensing Board. A copy of this document will have the same force and effect as the original.

_____ _____
Licensee Signature Witness Signature

Date: _____ Date: _____

_____
Date of Birth

_____
Date Accepted into VTO Program
(This document is only valid if licensee is accepted into program.)